

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0046060

Facility Name: Eastview Terrace

Address: 100 Eastview Place Sullivan 61951
Number City Zip Code

County: Moultrie

Telephone Number: (217) 728-7367 Fax # (217) 728-8405

HFS ID Number:

Date of Initial License for Current Owners: 02/01/00

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust

IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (309) 689-5869
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
State of Illinois, for the period from 1/1/2011 to 12/31/2011
and certify to the best of my knowledge and belief that the said contents
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than provider)
is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information
in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) Mark B. Petersen	
Paid Preparer	(Title) Chief Executive Officer	
	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

Facility Name & ID Number Eastview Terrace

0046060 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>9</u>	Skilled (SNF)	<u>9</u>	<u>3,285</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3	<u>54</u>	Intermediate (ICF)	<u>54</u>	<u>19,710</u>	<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>63</u>	TOTALS	<u>63</u>	<u>22,995</u>	<u>7</u>

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,221</u>	<u>1,221</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF	<u>11,467</u>	<u>3,074</u>	<u>101</u>	<u>14,642</u>	<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>11,467</u>	<u>3,074</u>	<u>1,322</u>	<u>15,863</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.98%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals for Inmates

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 2/1/2000

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 2/1/2000 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 9 and days of care provided 1,221

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Eastview Terrace # 0046060 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	157,467	16,961		174,428		174,428	3,200	177,628			1
2	Food Purchase		155,740		155,740		155,740	(111,118)	44,622			2
3	Housekeeping	89,671	18,040		107,711		107,711	21	107,732			3
4	Laundry		2,688		2,688		2,688		2,688			4
5	Heat and Other Utilities			55,042	55,042		55,042	209	55,251			5
6	Maintenance	26,714	10,072	20,869	57,655		57,655	1,305	58,960			6
7	Other (specify):* <u>Home Off. Ben. All.</u>							730	730			7
8	TOTAL General Services	273,852	203,501	75,911	553,264		553,264	(105,653)	447,611			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	629,608	51,433	236,370	917,411		917,411	32	917,443			10
10a	Therapy		9	84,863	84,872		84,872		84,872			10a
11	Activities	30,119	17	2,862	32,998		32,998		32,998			11
12	Social Services	23,453			23,453		23,453		23,453			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <u>Home Off. Ben. All.</u>											15
16	TOTAL Health Care and Programs	683,180	51,459	336,095	1,070,734		1,070,734	32	1,070,766			16
	C. General Administration											
17	Administrative			63,600	63,600		63,600	(5,639)	57,961			17
18	Directors Fees											18
19	Professional Services			14,100	14,100		14,100	3,661	17,761			19
20	Dues, Fees, Subscriptions & Promotions			4,561	4,561		4,561	257	4,818			20
21	Clerical & General Office Expenses	28,320	3,361	6,135	37,816		37,816	29,764	67,580			21
22	Employee Benefits & Payroll Taxes			121,493	121,493		121,493		121,493			22
23	Inservice Training & Education							107	107			23
24	Travel and Seminar			620	620		620	31	651			24
25	Other Admin. Staff Transportation			6,954	6,954		6,954	2,742	9,696			25
26	Insurance-Prop.Liab.Malpractice			24,583	24,583		24,583	742	25,325			26
27	Other (specify):* <u>Home Off. Ben. All.</u>							12,126	12,126			27
28	TOTAL General Administration	28,320	3,361	242,046	273,727		273,727	43,791	317,518			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	985,352	258,321	654,052	1,897,725		1,897,725	(61,830)	1,835,895			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			45,320	45,320		45,320	3,560	48,880			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			160,087	160,087		160,087	3,477	163,564			32
33	Real Estate Taxes			12,554	12,554		12,554	264	12,818			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,069	5,069		5,069	467	5,536			35
36	Other (specify):*											36
37	TOTAL Ownership			223,030	223,030		223,030	7,768	230,798			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,397		56,397		56,397		56,397			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,493	34,493		34,493		34,493			42
43	Other (specify):* Non-allowable Costs	37,965	1,637	145,613	185,215		185,215	(185,215)				43
44	TOTAL Special Cost Centers	37,965	58,034	180,106	276,105		276,105	(185,215)	90,890			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,023,317	316,355	1,057,188	2,396,860		2,396,860	(239,277)	2,157,583			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,328)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(726)	30		9
10	Interest and Other Investment Income	(1,682)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(331)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,002)	43		18
19	Entertainment				19
20	Contributions	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(134,995)	43		24
25	Fund Raising, Advertising and Promotional	(43,258)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(110,403)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (298,825)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	59,548	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 59,548		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (239,277)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,929)	43	1
2	X-Rays-Part A	(1,882)	43	2
3	Resident Flowers	(627)	43	3
4	Disallowed Special Events	(91)	43	4
5	Offset of Office Supplies Income	(69)	21	5
6	Offset of Jail Meals Income	(105,805)	2	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(110,403)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,200	\$ 3,200	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	15	15	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	21	21	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	209	209	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,305	1,305	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	730	730	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	32	32	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	63,600	Petersen Health Care, Inc.	100.00%	57,961	(5,639)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	3,661	3,661	12
13	V								13
14	Total			\$ 63,600			\$ 67,134	\$ * 3,534	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 257	\$ 257	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	29,833	29,833	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	107	107	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	31	31	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,742	2,742	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	742	742	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	12,126	12,126	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,286	4,286	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,159	5,159	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	264	264	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	467	467	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 56,014	\$ * 56,014	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

Eastview Terrace

0046060

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo				1
2			Arcola Health Care Center	Arcola				2
3			Aspen Rehab & Health Care	Silvis				3
4			Batavia Rehab & Health Care Center	Batavia				4
5			Bement Health Care Center	Bement				5
6			Benton Rehab & Health Care Center	Benton				6
7			Bloomington Rehab & Health Care Center	Bloomington				7
8			Casey Health Care Center	Casey				8
9			Charleston Rehab & Health Care Center	Charleston				9
10			Cisne Rehab & Health Care Center	Cisne				10
11			Countryview Care Center of Macomb	Macomb				11
12			Countryview Terrace	Louisville				12
13			Cumberland Rehab & Health Care Center	Greenup				13
14			Decatur Rehab & Health Care Center	Decatur				14
15			Eastside Health & Rehabilitation Center	Pittsfield				15
16			Eastview Terrace	Sullivan				16
17			El Paso Health Care Center	El Paso				17
18			Enfield Rehab & Health Care Center	Enfield				18
19			Farmer City Rehab & Health Care Center	Farmer City				19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Eastview Terrace

#

0046060

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Ozark Rehab & Health Care Center	Osage Beach, MO	Petersen Companies, LLC	Peoria	Mgmt/Bookkeeping	1
2			South Shore Health Care, LLC	Gary, IN	Petersen Health Care II, Inc.	Peoria	Mgmt/Bookkeeping	2
3			Cedargate Skilled Nursing Facility	Poplar Bluff, MO	Petersen Health Care, Inc.	Peoria	Mgmt/Bookkeeping	3
4			Tarkio Rehab & Health Care Center	Tarkio, MO	Petersen Health Enterprises, LLC	Peoria	Mgmt/Bookkeeping	4
5			Shangri-la Rehab & Living Center	Blue Springs, MO	Petersen Health Operations LLC	Peoria	Mgmt/Bookkeeping	5
6			Prairie Rose Care Center	Pana	Petersen Health Systems, Inc.	Peoria	Mgmt/Bookkeeping	6
7			Illini Heritage Rehab & Health Center	Champaign	Petersen Hotels LLC	Peoria	Hospitality	7
8			Courtyard Estates of Kewanee	Kewanee	Petersen Restaurants, LLC	Peoria	Restaurant	8
9			Courtyard Estates of Bradford	Bradford	Petersen Health Care IV, LLC	Peoria	Mgmt/Bookkeeping	9
10			Courtyard Estates of Galva	Galva	Petersen Health Care V, LLC	Peoria	Mgmt/Bookkeeping	10
11			Courtyard Estates of Walcott	Walcott	Petersen Health Care VI, LLC	Peoria	Mgmt/Bookkeeping	11
12			Courtyard Village of Kewanee	Kewanee	Petersen Health Care VII, LLC	Sullivan	Lessor	12
13			Lakewood Village	Charleston	Petersen Health Care VIII, LLC	Peoria	Mgmt/Bookkeeping	13
14			Courtyard Estates of Monmouth	Monmouth	Petersen Health Care X, LLC	Peoria	Lessor	14
15			Riverview Estates	Havana	Petersen Osage Beach, LLC	Osage Beach, MO	Lessor	15
16			Simple Blessings	Casey	Petersen West Frankfort, LLC	West Frankfort	Lessor	16
17			Courtyard Estates of Bushnell	Bushnell	Midwest Health Care, LLC	Peoria	Mgmt/Bookkeeping	17
18			Courtyard Estates of Canton	Canton	Poplar Bluff Health Care, LLC	Poplar Bluff, MO	Lessor	18
19			Legacy Estates of Monmouth	Monmouth	Petersen Roseville, LLC	Roseville	Lessor	19
20			Courtyard Estates of Sullivan	Sullivan				20
21			Courtyard Estates of Peoria	Peoria				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1											1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Eastview Terrace# 0046060

Report Period Beginning:

1/1/2011Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,542,131	77	\$ 311,109	\$ 308,619	15,863	\$ 3,200	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	15,863	15	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	15,863	21	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	15,863	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	15,863	209	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	15,863	1,305	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	15,863	730	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	15,863	32	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	15,863	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	15,863	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	15,863	57,961	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	15,863	3,661	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	15,863	257	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	15,863	29,833	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	15,863	107	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	15,863	31	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	15,863	2,742	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	15,863	742	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	15,863	12,126	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	15,863	4,286	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	15,863	5,159	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	15,863	264	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	15,863	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	15,863	467	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 123,148	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		X	Mortgage	Varies	1/17/07	\$ 3,075,000	\$ 2,852,233	12/31/2013	Varies	\$ 160,087	1
2												2
3								Interest Income Offset			(1,682)	3
4								Home Office Allocation-PHC			5,159	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 3,075,000	\$ 2,852,233			\$ 163,564	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,075,000	\$ 2,852,233			\$ 163,564	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

HFS 3745 (N-4-99)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	12,745	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2010		\$	12,459	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(286)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	12,840	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.						
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			Home Office Allocation	\$	264	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	12,818	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	12,544	8		
		2007	12,188	9		
		2008	12,163	10		
		2009	12,343	11		
		2010	12,459	12		
Accrual based on prior year tax bill.						

- NOTES:
- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
 - 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Eastview Terrace

COUNTY

Moultrie

FACILITY IDPH LICENSE NUMBER

0046060

CONTACT PERSON REGARDING THIS REPORT

Mark Petersen

TELEPHONE

(309)691-8113

FAX #:

(309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-08-01-202037</u>	<u>Long-Term Care Facility</u>	\$ <u>12,458.54</u>	\$ <u>12,458.54</u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u><u>12,458.54</u></u>	\$ <u><u>12,458.54</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

- A.

Square Feet:

13,082
- B.

General Construction Type:

Exterior

Block

Frame

Steel

Number of Stories

1
- C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

- F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	217,546	2000	\$ 100,000	1
2					2
3	TOTALS	217,546		\$ 100,000	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57		2000	1976	\$ 982,565	\$	39	\$ 25,194	\$ 25,194	\$ 301,278	4
5	6		2000	1985							5
6											6
7											7
8											8
	Improvement Type**										
9	Water Heater		2000	4,800		7				4,800	9
10	Concrete Pad		2000	500		20	25		25	223	10
11	Painting Exterior Building		2000	2,480		5				2,480	11
12	Fence		2000	3,953		15	264		264	2,951	12
13	Asphalt Parking Lot		2000	2,370		15	158		158	1,580	13
14	Carpet		2000	503		7				503	14
15	Flooring		2001	72,265		39	1,853		1,853	21,756	15
16	Remodeling		2001	6,245		39	160		160	1,897	16
17	Roofing		2001	2,159		39	55		55	642	17
18	Roofing		2001	12,000		39	308		308	3,448	18
19	Replacement - Glass		2001	1,179		7				1,179	19
20	Medicare wing upgrade		2002	89,018		39	2,283		2,283	24,338	20
21	Roofing		2002	14,200		39	364		364	3,841	21
22	Flooring		2002	4,263		39	109		109	1,140	22
23	Architects Fee		2002	1,916		39	49		49	491	23
24	Wall hangings		2002	3,220		7				3,220	24
25	Paving of Parking Lot		2004	4,200		15	280		280	2,123	25
26	Window Balance		2004	1,714		7	189		189	1,714	26
27	Driveway renovation		2005	1,100		20	55		55	379	27
28	Grease interceptor		2005	15,589		20	779		779	4,841	28
29	Sidewalks		2005	4,919		20	246		246	1,503	29
30	Sealcoating		2006	5,650		8	706		706	3,883	30
31	Pipe Work		2006	3,700		25	148		148	814	31
32	Sidewalks		2007	4,420		15	295		295	1,327	32
33	Replace Exterior Storage Shed (Including Demolition of Old)		2008	5,000		20	250		250	875	33
34	Wall Flashing-Dining Room		2011	4,700		15	157		157	157	34
35	Sprinkler System Replacement		2011	45,990		15	1,533		1,533	1,533	35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60	Land Improvements Booked			951			(951)		60
61	Building Booked			25,194			(25,194)		61
62	Building Improvement Booked			9,379			(9,379)		62
63									63
64	2011-Home Office Allocation-Building Improvements		7,550			181	181		64
65	2011-Home Office Allocation-Land Improvements		705			45	45		65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,308,873	\$ 35,524		\$ 35,686	\$ 162	\$ 394,916	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$23,692	\$4,130	\$2,369	\$(1,761)	5-10 yrs.	\$8,210	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	283,990					283,990	73
74	Home Office Allocation			5,159	5,159			74
75	TOTALS	\$307,682	\$4,130	\$7,528	\$3,398		\$292,200	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Plymouth Voyager 2000	2000	\$42,307	\$	\$	\$		\$42,307	76
77	Resident Care	Malibu 2000	2001	11,054					11,054	77
78	Resident Care	Ford Econoline Van 2007	2007	28,328	5,666	5,666		5 yrs.	25,024	78
79										79
80	TOTALS			\$81,689	\$5,666	\$5,666	\$		\$78,385	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,798,244	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$45,320	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$48,880	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$3,560	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$765,501	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$5,536
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year EndingAnnual Rent
12. /2012\$
13. /2013\$
14. /2014\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Eastview Terrace
0046060

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 14A

XII. Rental Costs
 B. Equipment
 16. Description of rental amount for movable equipment

Medical Equipment	\$	2,018
Dishwasher		-
Laundry Equipment		-
Copier		3,051
Home Office Allocation		467
		<u>5,536</u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	☐ YES ☒ NO	2. CLASSROOM PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY COMMUNITY COLLEGE HOURS PER CNA	3. CLINICAL PORTION: IN-HOUSE PROGRAM IN OTHER FACILITY HOURS PER CNA
---	---	---	---

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
					Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,788	\$ 26,827	\$	1,788	\$ 26,827	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,180	17,695		1,180	17,695	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		2,689	40,341	9	2,689	40,350	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				56,397		56,397	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	5,657	\$ 84,863	\$ 56,406	5,657	\$ 141,269	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,842,365	\$ 3,842,365	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 115,000)	604,942	604,942	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,084	20,084	6
7	Other Prepaid Expenses	14,735	14,735	7
8	Accounts Receivable (owners or related parties)	687,672	687,672	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,169,798	\$ 5,169,798	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	114,270	100,000	13
14	Buildings, at Historical Cost	982,565	990,115	14
15	Leasehold Improvements, at Historical Cost	297,268	318,758	15
16	Equipment, at Historical Cost	395,885	389,371	16
17	Accumulated Depreciation (book methods)	(761,174)	(765,501)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Goodwill	320,669	320,669	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,349,483	\$ 1,353,412	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,519,281	\$ 6,523,210	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 402,385	\$ 402,385	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	65,359	65,359	30
	Accrued Taxes Payable (excluding real estate taxes)	4,816	4,816	31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,840	12,840	32
33	Accrued Interest Payable	14,334	14,334	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	31,047	31,047	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 530,781	\$ 530,781	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,852,233	2,852,233	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	A/P-Other	3,221	3,221	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,855,454	\$ 2,855,454	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,386,235	\$ 3,386,235	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,133,046	\$ 3,136,975	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,519,281	\$ 6,523,210	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,237,974	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4	Prior Period Adjustment-Management Fees	(64,000)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,173,971	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(40,925)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (40,925)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,133,046	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Eastview Terrace

0046060

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,055,097	1
2	Discounts and Allowances for all Levels	(100,771)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,954,326	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	177,843	6
7	Oxygen	3,161	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 181,004	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,328	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	99,088	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,526	20
21	Other Medical Services	3,107	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 113,049	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,682	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,682	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	69	28
28a	Jail Meals Revenue	105,805	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 105,874	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,355,935	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	553,264	31
32	Health Care	1,070,734	32
33	General Administration	273,727	33
	B. Capital Expense		
34	Ownership	223,030	34
	C. Ancillary Expense		
35	Special Cost Centers	241,612	35
36	Provider Participation Fee	34,493	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,396,860	40
41	Income before Income Taxes (line 30 minus line 40)**	(40,925)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (40,925)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	465	465	\$ 16,471	\$ 35.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,784	4,950	113,894	23.01	3
4	Licensed Practical Nurses	8,254	8,604	164,195	19.08	4
5	CNAs & Orderlies	26,684	27,496	285,435	10.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,838	1,896	30,119	15.89	9
10	Activity Assistants					10
11	Social Service Workers	1,860	2,020	23,453	11.61	11
12	Dietician					12
13	Food Service Supervisor	1,975	2,015	31,201	15.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,149	13,859	126,266	9.11	15
16	Dishwashers					16
17	Maintenance Workers	2,015	2,055	26,714	13.00	17
18	Housekeepers	9,435	9,658	89,671	9.28	18
19	Laundry					19
20	Administrator	2,080	2,080	57,961	27.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,981	1,989	28,320	14.24	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	4,418	4,483	87,578	19.54	33
34	TOTAL (lines 1 - 33)	78,938	81,570	\$ 1,081,278 *	\$ 13.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,844	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,844		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,924	\$ 73,129	L10, C3	50
51	Licensed Practical Nurses	1,160	44,640	L10, C3	51
52	Certified Nurse Assistants/Aides	4,917	115,526	L10, C3	52
53	TOTAL (lines 50 - 52)	8,001	\$ 233,295		53

Eastview Terrace

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,338	2,403	49,613	20.65
Marketing	2,080	2,080	37,965	18.25
TOTAL	4,418	4,483	87,578	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Carla Miller		Administrator	0	\$ 24,106	Workers' Compensation Insurance		\$ 18,980	IDPH License Fee		\$ 1,990	
Adam Pullen		Administrator	0	33,855	Unemployment Compensation Insurance		21,429	Advertising: Employee Recruitment		1,285	
					FICA Taxes		77,362	Health Care Worker Background Check			
					Employee Health Insurance		1,866	(Indicate # of checks performed)			
					Employee Meals			Patient Background Checks		126 1,265	
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		21	
					Employee Relations		462	Home Office Allocation		257	
					Employee Retirement		1,394				
TOTAL (agree to Schedule V, line 17, col. 1)								Less: Public Relations Expense		()	
(List each licensed administrator separately.)				\$ 57,961				Non-allowable advertising		()	
								Yellow page advertising		()	

*** Attach copy of IMRF notifications**

****See instructions.**

Eastview Terrace
0046060
Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		14,100
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	4
Henry County Recorder	Legal	-
Ginoli & Company	Accountants	508
Miscellaneous Vendors	Computer Services	41
Advanced Answers on Demand	Computer Services	2,124
Access 2 Go	Computer Services	209
Kemper Technology	Computer Services	97
MediFax	Computer Services	33
VisionShare/Ability Network	Computer Services	149
Advanced System Design	Computer Services	196
Simple LTC	Computer Services	245
Optimizer Systems	Other Prof Fees	25
Clifton Gunderson	Other Prof Fees	9
Mike Miller	Other Prof Fees	12
OIC Group	Other Prof Fees	3
AllScripts	Other Prof Fees	6
Total (agree to Schedule V, line 19, column 8)		<u>17,761</u>

Eastview Terrace
0046060

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility

	Invoice	Allocation	
Vendor/Payee	Total	%	Total
Heyl, Royster, Voelker, and Allen	4,140.91	100%	4,141
Heyl, Royster, Voelker, and Allen	506.00	100%	506
Heyl, Royster, Voelker, and Allen	3,517.85	100%	3,518
Heyl, Royster, Voelker, and Allen	75.00	100%	75
Home Office Allocation			
Heyl, Royster, Voelker & Allen	4.00	100.00%	4
Total Legal Fees			8,244

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

No
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 10,563 Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A
- (9)

Are you presently operating under a sublease agreement?

YES X NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 34,493
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

N/A
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes
Indicate the amount. \$ 5,328
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes

c.

What percent of all travel expense relates to transportation of nurses and patients?

N/A

d.

Have vehicle usage logs been maintained?

Adequate records have been maintained.

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

N/A
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Ginoli & Company

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees

Yes